

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN7508</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/10/2018</b>
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TENNESSEE VETERANS HOME**

**PO BOX 10299**

**MURFREESBORO, TN 37129**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	<p>1200-8-6 No Deficiencies</p> <p>This Rule is not met as evidenced by: During the Fire Safety portion of the annual licensure survey conducted on 09/10/2018, no deficienices were cited under the Tennessee Department of Health, Board for Licensing health Care Facilities, Chapter 1200-08-06, Standard for Nursing Homes.</p>	N 002		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

5ZX421

If continuation sheet 1 of 1